AMENDED IN ASSEMBLY MAY 2, 2001

AMENDED IN ASSEMBLY APRIL 16, 2001

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL No. 32

Introduced by Assembly Member Richman, *Senator Figueroa, and* ***Assembly Member Chan***
(Principal coauthor: Assembly Member Thomson)
(Coauthors: Assembly Members Aanestad and Koretz)

December 4, 2000

An act to add Article 4.6 (commencing with Section 1366.40) ~~and Article 4.7 (commencing with Section 1366.50) to Chapter 2.2 of~~ *to Chapter 2.2 of* Division 2 of, and to add Division 99 (commencing with Section 99000) to, the Health and Safety Code, and ~~to amend Section 12725 of,~~ to add Article 1.8 (commencing with Section 10128.70) to Chapter 1 of ~~Division 2 of, to add Chapter 8.6 (commencing with Section 10790) to~~ Part 2 of Division 2 of, and to add Part 6.25 (commencing with Section 12694) to Division 2 of, the Insurance Code, relating to health insurance, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 32, as amended, Richman. Health care coverage: Cal-Health program~~: Major Risk Medical Insurance Program~~.

(1) Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care, and for licensing and regulation of disability insurers by the Department of Insurance. A violation of the provisions governing health care service plans is a crime.

Existing law provides for creation of various programs to provide health care services to persons with limited incomes and meeting various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board and the Medi-Cal program administered by the State Department of Health Services. The board also administers the Major Risk Medical Insurance Program that provides access to health care coverage for persons who have been unable to obtain coverage due to preexisting medical conditions.

This bill would create the Cal-Health program, which would result in coordination of the Healthy Families and Medi-Cal programs by providing a uniform and simplified application process and would expand eligibility under these programs to additional uninsured persons. The bill would require the state to apply to the federal government for waivers to allow federal funds to be used in that regard but would allow funding of expanded eligibility through state-only funding in the meantime. The bill would authorize providers to determine presumptive eligibility of a person for Cal-Health at the time the person is provided with medical care, and would require full reimbursement of the provider for reasonable services rendered. The bill would enact other related provisions.

Existing law creates the Healthy Families Fund, which is continuously appropriated to the board for the purposes of funding the Healthy Families program.

Because this bill would result in increased expenditures from the fund by expanding eligibility under the Healthy Families program, this bill would make an appropriation. By expanding eligibility for the Medi-Cal program, which is currently determined by counties, the bill would impose a state-mandated local program by expanding the scope of those duties.

This bill would require the board, health care service plans, and disability insurers to offer a standard uniform benefit package. The standard uniform benefit package would only be required to provide coverage for certain basic health care services and would be exempt from coverage mandates otherwise applicable. The bill would provide that a person not eligible for coverage under the Cal-Health program could purchase a standard uniform benefit package through that program. ~~The bill would also impose an 18-month limit for coverage under the Major Risk Medical Insurance Program administered by the board that provides access to coverage to persons who are otherwise~~

~~unable to obtain health care coverage, but would require health care service plans and disability insurers to provide guaranteed coverage to persons once they have been enrolled in that program, as specified.~~ By imposing new requirements on health care service plans, this bill would create a new crime and thereby impose a state-mandated local program.

The bill would also declare the intent of the Legislature in this regard.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: $^2/_3$. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the Cal-Health Act.

SEC. 2. The Legislature finds and declares all of the following:

(a) It is the intent of the Legislature to address the problem of Californians who do not have health insurance by reforming California's health care system and phasing in a consolidated approach that will provide access for all Californians to a basic health insurance plan.

(b) It is the intent of the Legislature through this act to offer affordable and accessible health care coverage to all Californians currently without health insurance for themselves and their children.

(c) The Legislature intends to accomplish this end by (1) providing easy one-step streamlined access for the currently uninsured to California's existing health care programs by

consolidating those programs and providing for accelerated enrollment for those programs, (2) expanding those programs to cover more of the uninsured using federal funds whenever possible, (3) and providing for affordable coverage for those who do not qualify for state programs but who still lack the means or opportunity to obtain private health care coverage.

(d) For those individuals who are not currently eligible for the Medi-Cal or the Healthy Families programs, but who still earn too little to afford health insurance, Cal-Health shall contract, on a competitive basis, with health care service plans and insurers to offer a range of coverage options, including a new standard uniform benefit package (SUBP). The SUBP will offer basic health care coverage, including inpatient and outpatient hospital care, physician care, diagnostic services, mental health services, preventive services, and prescription drugs, and will be exempt from certain mandated coverages now required by law to be offered by existing health plans.

(e) The working poor and others with family incomes at or below 250 percent of the federal poverty level, will be eligible for Cal-Health, and will receive health care benefits either through the Medi-Cal or Healthy Families programs. California will seek a waiver from the federal Health Care Financing Administration in order to allow increased enrollment in those programs while benefiting from federal matching funds.

(f) The Cal-Health program shall be responsible for creating and implementing programs reaching out to and enrolling individuals and children in the Medi-Cal and Healthy Family programs. To this end, Cal-Health will work with hospitals, preschools, and elementary and secondary schools to ensure that individuals and children already eligible for these programs enroll and receive benefits.

(g) Small employers that have employees with family income of more than 250 percent of the federal poverty level and individuals with family incomes of more than 250 percent of the federal poverty level shall have the ability to purchase a standard minimum basic health insurance plan through a shared purchasing pool mechanism.

(h) Health care service plans and health insurers shall offer SUBP as a condition of licensure in California.

SEC. 3. Article 4.6 (commencing with Section 1366.40) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 4.6. Cal-Health Program

1366.40. Every health care service plan that covers hospital, medical, or surgical expenses shall offer, through the Cal-Health Program created pursuant to Division 99 (commencing with Section 99000), a standard uniform benefit package (SUBP) as described by Section 12694.1 of the Insurance Code.

1366.41. Notwithstanding any other provision of law, the SUBP shall only be required to provide coverage for the basic health care services described in Section 12694.1 of the Insurance Code and shall be exempt from other coverage mandates that would otherwise be required.

~~SEC. 4. Article 4.7 (commencing with Section 1366.50) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:~~

~~Article 4.7. Coverage for Persons Terminated From the Major Risk Medical Insurance Program~~

~~1366.50. (a) As used in this article, ''program'' means the Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code).~~

~~(b) As used in this article, ''eligible individual'' means an individual eligible to purchase coverage pursuant to Section 1366.51.~~

~~1366.51. (a) A health care service plan providing coverage for hospital, medical, or surgical benefits under an individual health care service plan contract may not, with respect to an individual who has received coverage under the program for at least 18 months, and who desires to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the individual plan contract.~~

~~(b) The requirements of subdivision (a) shall apply only if the individual who is seeking coverage meets all of the following conditions:~~

~~(1) The individual has received notice of termination from the program pursuant to subdivision (d) of Section 12725 of the Insurance Code.~~

~~(2) The individual was not terminated from the program due to nonpayment of premiums or fraud.~~

~~(3) The individual is not currently eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage, except to the extent that the individual is currently covered under the program and is requesting coverage under the individual plan contract to begin following the upcoming termination of his or her coverage pursuant to subdivision (c) of Section 12725 of the Insurance Code.~~

~~(4) The individual applies for coverage under an individual plan contract pursuant to this article not later than __ days after termination of coverage under the program.~~

~~(c) (1) In the case of a health care service plan that offers health insurance coverage in the individual market through a network plan, the plan may do both of the following:~~

~~(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.~~

~~(B) Within the service area of the plan, deny coverage to individuals if the plan has demonstrated to the director that the plan will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contractholders and enrollees and individual enrollees, and that the plan is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals have participated in the program.~~

~~(2) A health care service plan, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer coverage in the individual market within that service area for a period of 180 days after the coverage is denied.~~

~~(d) (1) A health care service plan may deny health insurance coverage in the individual market to an individual who is eligible for coverage under this section if the plan has demonstrated to the director both of the following:~~

~~(A) The plan does not have the financial reserves necessary to underwrite additional coverage.~~

~~(B) The plan is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals have participated in the program.~~

~~(2) A health care service plan, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the issuer has demonstrated to the director that the plan has sufficient financial reserves to underwrite additional coverage, whichever is later.~~

~~(e) A health care service plan shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of eligible individuals in the same manner and consistent with the renewal commission amounts as the plan compensates life agents or fire and casualty broker-agents for other enrollees who are not eligible individuals and who are purchasing the same individual health benefit plan contract.~~

~~(f) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.~~

~~(g) This section shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2002.~~

~~1366.52. (a) Commencing January 1, 2002, a plan shall fairly and affirmatively offer, market, and sell the health care service plan contracts described in Section 1366.51 that are sold to individuals or to associations that include individuals to all eligible individuals in each service area in which the plan provides or arranges for the provision of health care services. Each plan shall make available to each eligible individual all health care service plan contracts that the plan offers and sells to individuals or to associations that include individuals.~~

~~(b) The plan may not reject an application from an eligible individual under the following circumstances:~~

~~(1) The eligible individual agrees to make the required premium payments.~~

~~(2) The eligible individual, and his or her dependents who are to be covered by the plan contract, work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.~~

~~(c) No plan or solicitor shall, directly or indirectly, encourage or direct eligible individuals to refrain from filing an application for coverage with a plan because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location provided that the location is within the plan's approved service area.~~

~~1366.53. (a) After an eligible individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the eligible individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed.~~

~~(b) In no case shall the premium charged for any health care service plan contract sold to any individual pursuant to Section 1366.51 exceed __ percent of the standard premium charged to an individual who is the same age and resides in the same geographic area as the eligible individual. A plan may adjust the premium based on family size, not to exceed __ percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the eligible individual. The premium for an eligible individual may not be modified more frequently than once every 12 months.~~

~~(c) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the eligible individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.~~

~~(d) After the plan has notified an eligible individual of his or her actual premium charges for that plan contract and has accepted the eligible individual's application for coverage, the eligible individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.~~

~~(e) When an eligible individual submits a premium payment, based on the quoted premium charges, the effective date of coverage shall be determined as follows: (1) if the payment is~~

~~delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month, or (2) if the payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment. However, coverage for an eligible individual who has been notified of termination of coverage under the program shall not become effective before the date that coverage under the program has terminated.~~

~~(f) During the first 30 days after the effective date of the plan contract, the eligible individual shall have the option of changing coverage to any other individual plan contract offered by the same health care service plan. If the eligible individual notified the plan of the change within the first 15 days of the month, coverage under the new plan contract shall become effective no later than the first day of the following month. If an enrolled eligible individual notified the plan of the change after the 15th day of the month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.~~

~~1366.54. A plan may not exclude any eligible individual, or his or her dependents, who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that eligible individual or dependent. No plan contract may limit or exclude coverage for a specific eligible individual, or his or her dependents, by type of illness, treatment, medical condition, or accident.~~

~~1366.55. All health care service plan contracts offered to an eligible individual shall be renewable with respect to the individual and dependents at the option of the contractholder except in the case of any of the following:~~

~~(a) Nonpayment of the required premiums.~~

~~(b) Fraud or misrepresentation by the contractholder.~~

~~(c) The plan ceases to provide or arrange for the provision of health care services for individual health care service plan contracts in this state, provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing individual health care service plan contracts in this state is provided to the director and to the contractholder.~~

~~(2) Individual health care service plan contracts subject to this article shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any plan that ceases to offer for sale new individual health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.~~

~~(3) A plan that ceases to write new individual business in this state after January 1, 2002, shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of three years from the date of the notice to the director.~~

~~(d) When the plan withdraws a health care service plan contract from the individual market, provided that the plan makes available to eligible individuals all plan contracts that it makes available to new individual business, and provided that the premium for the new plan contract complies with the renewal increase requirements applicable to federally eligible defined individuals set forth in Section 1399.811.~~

~~1366.56. Plans shall apply premiums consistently with respect to all eligible individuals who apply for coverage.~~

~~SEC. 5.~~

SEC. 4. Division 99 (commencing with Section 99000) is added to the Health and Safety Code, to read:

DIVISION 99. CAL-HEALTH PROGRAM

99000. It shall be the responsibility of the State of California to make its best efforts to provide that all persons who are eligible for the Healthy Families or Medi-Cal programs, or for other governmental health care coverage or assistance, are enrolled in programs and services for which they are eligible.

99001. (a) There is hereby created the California Health Care Program (Cal-Health) to provide comprehensive health care services to residents of this state. Cal-Health shall coordinate the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) through the State Department of Health Services and the Healthy Families program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code) through the Managed Risk Medical Insurance Board.

(b) (1) Children and their parents or primary caretaker living with them shall be eligible to participate in Cal-Health if their family income is at or below 250 percent of the federal poverty level.

(2) Funding for these persons shall be determined as follows:

(A) For persons with a family income at or below 133 percent of the federal poverty level, funding for Cal-Health shall be through the Medi-Cal program.

(B) For persons with a family income above 133 percent but not exceeding 250 percent of the federal poverty level, funding for Cal-Health shall be through the Healthy Families program.

(3) The state shall seek a waiver from the Health Care Financing Administration through the Section 1115 waiver process to permit federal Medicaid funds to be used to pay for Medi-Cal coverage for childless adults with family incomes at or below 250 percent of the federal poverty level. Pending approval of a waiver, these childless adults shall be included in Cal-Health through state-only funding.

(c) There shall be a simple, uniform mail-in application and enrollment process for all persons covered by Cal-Health. All applications for Cal-Health shall be sent to the same Cal-Health address. Participating providers shall, for the purpose of accelerating enrollment, be permitted to provide persons seeking medical care with Cal-Health applications at the place and time that medical services are sought. Participating providers shall be empowered to determine presumptive eligibility for Cal-Health programs at that time, and shall be fully reimbursed for reasonable services rendered pursuant to federal or state law.

(d) (1) The Cal-Health enrollment and application process shall secure sufficient information to ensure that Cal-Health is able to perform screening and referral for persons not eligible for Cal-Health programs, but potentially eligible for other health care programs not administered by Cal-Health.

(2) The California Health and Human Services Agency shall convene a working group including, but not limited to, representatives of low-income patients and representatives of the State Department of Health Services and the Managed Risk Medical Insurance Board. The working group shall advise Cal-Health on the enrollment and application process, and shall be convened as quickly as possible after January 1, 2002.

(e) To the extent permitted by federal law, Cal-Health eligibility rules for the Medi-Cal and Healthy Families programs shall be the same, notwithstanding any other provision of law. To the extent that differences in eligibility rules remain, those differences shall not be reflected in any enrollment or other materials available to potential Cal-Health applicants but shall be implemented administratively by Cal-Health.

(f) Preschools and public elementary and secondary schools, with respect to each enrolled child, shall inform the parent or primary caretaker living with the child at least once each year about the Cal-Health program and its eligibility requirements, and shall allow an application to be submitted at the preschool or school.

(g) All licensed hospitals, clinics, and other health facilities, relative to a child who is seen or admitted, shall inform the parent or primary caretaker of the child about the Cal-Health program and its eligibility requirements at the time the child is seen or admitted, and shall allow an application to be submitted while the child is at the hospital, clinic, or facility. A parent who gives birth to a child at a hospital, clinic, or facility shall be similarly informed and provided an opportunity to submit an application relative to that child.

(h) The California Health and Human Services Agency shall study the feasibility of simplifying the Medi-Cal Health Insurance Premium Payment Program and the Medi-Cal Employer Group Health Program to increase participation by employees and employers in private market coverage and employer-sponsored coverage.

(i) Cal-Health shall undertake a pilot project to assist small businesses in learning about health insurance products and costs, administering employer-sponsored coverage, and enrolling eligible individuals in Cal-Health. The purpose of the pilot project shall be to assist businesses with fewer than 50 employees to provide health insurance to their employees and dependents of those employees by providing information, administrative services, and enrollment assistance for Cal-Health for eligible employees.

99002. With respect to individuals eligible for Cal-Health programs, the State of California shall be responsible for all medically necessary health care services rendered to those

individuals, and shall reimburse health care providers for those services at the reimbursement rates applicable to those programs as otherwise required by law.

99003. Persons who are otherwise ineligible for Cal-Health programs pursuant to Section 99001 shall be eligible to purchase a standard uniform benefit package (SUBP) as defined in Section 12694.1 of the Insurance Code.

~~SEC. 6.~~

SEC. 5. Article 1.8 (commencing with Section 10128.70) is added to Chapter 1 of Division 2 of the Insurance Code, to read:

Article 1.8. Cal-Health Program

10128.70. Every disability insurer that offers hospital, medical, and surgical coverage shall offer, through the Cal-Health Program created pursuant to Division 99 (commencing with Section 99000) of the Health and Safety Code, a standard uniform benefit package (SUBP) as described by Section 12694.1.

10128.71. Notwithstanding any other provision of law, the standard uniform benefit package (SUBP) shall only be required to provide coverage for the basic health care services described in Section 12694.1, and shall be exempt from other coverage mandates that would otherwise be required.

~~SEC. 7. Chapter 8.6 (commencing with Section 10790) is added to Part 2 of Division 2 of the Insurance Code, to read:~~

~~CHAPTER 8.6. COVERAGE FOR PERSONS TERMINATED FROM THE MAJOR RISK MEDICAL INSURANCE PROGRAM~~

~~10790. (a) As used in this chapter, "program" means the Major Risk Medical Insurance Program (Part 6.5 commencing with Section 12700).~~

~~(b) As used in this chapter, "eligible individual" means an individual eligible to purchase coverage pursuant to Section 10791.~~

~~10791. (a) A disability insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan may not, with respect to an individual who has received coverage under the program for at least 18 months, and who desires to enroll in individual health insurance coverage, decline to offer coverage to,~~

~~or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.~~

~~(b) The requirements of subdivision (a) shall apply only if the individual who is seeking coverage meets all of the following conditions:~~

~~(1) The individual has received notice of termination from the program pursuant to subdivision (d) of Section 12725 of the Insurance Code.~~

~~(2) The individual was not terminated from the program due to nonpayment of premiums or fraud.~~

~~(3) The individual is not currently eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage, except to the extent that the individual is currently covered under the program and is requesting coverage under the individual health benefit plan to begin following the upcoming termination of his or her coverage pursuant to subdivision (c) of Section 12725 of the Insurance Code.~~

~~(4) The individual applies for coverage under an individual health benefit plan pursuant to this chapter not later than __ days after termination of coverage under the program.~~

~~(c) (1) In the case of a disability insurer that offers health insurance coverage in the individual market through a network plan, the insurer may do both of the following:~~

~~(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.~~

~~(B) Within the service area covered by the health benefit plan, deny coverage to individuals if the plan has demonstrated to the commissioner that the insurer will not have the capacity to deliver services adequately to additional individual insureds because of its obligations to existing group policyholders and insureds and individual insureds, and that the insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals have participated in the program.~~

~~(2) A disability insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer coverage in the individual market~~

~~within that service area for a period of 180 days after the coverage is denied.~~

~~(d) (1) A disability insurer may deny health insurance coverage in the individual market to an individual who is eligible for coverage under this section if the insurer has demonstrated to the commissioner both of the following:~~

~~(A) The insurer does not have the financial reserves necessary to underwrite additional coverage.~~

~~(B) The insurer is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals have participated in the program.~~

~~(2) A disability insurer, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the insurer has demonstrated to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.~~

~~(e) A disability insurer shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of eligible individuals in the same manner and consistent with the renewal commission amounts as the insurer compensates life agents or fire and casualty broker-agents for other insureds who are not eligible individuals and who are purchasing the same individual health benefit plan contract.~~

~~(f) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.~~

~~(g) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2002.~~

~~10792. (a) Commencing January 1, 2002, a disability insurer shall fairly and affirmatively offer, market, and sell the health benefit plans described in Section 10791 that are sold to individuals or to associations that include individuals to all eligible individuals in each service area in which the insurer provides coverage for health care services. Each insurer shall make available to each eligible individual all health benefit plans that the insurer offers and sells to individuals or to associations that include individuals.~~

~~(b) The insurer may not reject an application from an eligible individual under the following circumstances:~~

~~(1) The eligible individual agrees to make the required premium payments.~~

~~(2) The eligible individual, and his or her dependents who are to be covered by the health benefit plan, work or reside in the service area in which the insurer provides coverage for health care services.~~

~~(c) No insurer or agent or broker shall, directly or indirectly, encourage or direct eligible individuals to refrain from filing an application for coverage with an insurer because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location provided that the location is within the insurer's approved service area.~~

~~10793. (a) After an eligible individual submits a completed application form for a health benefit plan, the insurer shall, within 30 days, notify the eligible individual of the individual's actual premium charges for that health benefit plan, unless the insurer has provided notice of the premium charge prior to the application being filed.~~

~~(b) In no case shall the premium charged for any health benefit plan sold to any individual pursuant to Section 10791 exceed __ percent of the standard premium charged to an individual who is the same age and resides in the same geographic area as the eligible individual. An insurer may adjust the premium based on family size, not to exceed __ percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the eligible individual. The premium for an eligible individual may not be modified more frequently than once every 12 months.~~

~~(c) For a health benefit plan that an insurer has discontinued offering, the premium applied to the first rating period of the new health benefit plan that the eligible individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued health benefit plan.~~

~~(d) After the insurer has notified an eligible individual of his or her actual premium charges for that health benefit plan and has accepted the eligible individual's application for coverage, the~~

~~eligible individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.~~

~~(e) When an eligible individual submits a premium payment, based on the quoted premium charges, the effective date of coverage shall be determined as follows: (1) if the payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month, or (2) if the payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment. However, coverage for an eligible individual who has been notified of termination of coverage under the program shall not become effective before the date that coverage under the program has terminated.~~

~~(f) During the first 30 days after the effective date of the health benefit plan, the eligible individual shall have the option of changing coverage to any other individual health benefit plan offered by the same insurer. If the eligible individual notified the insurer of the change within the first 15 days of the month, coverage under the new health benefit plan shall become effective no later than the first day of the following month. If an enrolled eligible individual notified the insurer of the change after the 15th day of the month, coverage under the new health benefit plan shall become effective no later than the first day of the second month following notification.~~

~~10794. An insurer may not exclude any eligible individual, or his or her dependents, who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that eligible individual or dependent. No health benefit plan may limit or exclude coverage for a specific eligible individual, or his or her dependents, by type of illness, treatment, medical condition, or accident.~~

~~10795. All health benefit plans offered to an eligible individual shall be renewable with respect to the individual and dependents at the option of the enrolled individual except in the case of any of the following:~~

~~(a) Nonpayment of the required premiums.~~

~~(b) Fraud or misrepresentation by the enrolled individual.~~

~~(c) The plan ceases to provide or arrange for the provision of health care services for individual health benefit plan contracts in this state, provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the contractholder.~~

~~(2) Individual health benefit plans subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of an insurer that remains in force, any insurer that ceases to offer for sale new individual health benefit plan contracts shall continue to be governed by this chapter with respect to business conducted under this chapter.~~

~~(3) An insurer that ceases to write new individual business in this state after January 1, 2002, shall be prohibited from offering for sale new individual health benefit plan contracts in this state for a period of three years from the date of the notice to the commissioner.~~

~~(d) When the insurer withdraws a health benefit plan contract from the individual market, provided that the insurer makes available to eligible individuals all health benefit plan contracts that it makes available to new individual business, and provided that the premium for the new health benefit plan contract complies with the renewal increase requirements applicable to federally eligible defined individuals set forth in Section 10901.9.~~

~~10796. Insurers shall apply premiums consistently with respect to all eligible individuals who apply for coverage.~~

~~SEC. 8.~~

SEC. 6. Part 6.25 (commencing with Section 12694) is added to Division 2 of the Insurance Code, to read:

PART 6.25. CAL-HEALTH PROGRAM

12694. The Major Risk Medical Insurance Board shall contract, on a competitive basis, with health care service plans and disability insurers to provide a range of health care coverage options, including a standard uniform benefit package (SUBP).

12694.1. The standard uniform benefit package (SUBP) shall consist of medically necessary health care coverage for all of the following:

(a) Inpatient and outpatient hospital care, including 24-hour-per-day emergency services.

(b) Outpatient, inpatient, home-based, and office-based care by physicians.

(c) Diagnostic laboratory and diagnostic therapeutic radiologic services.

(d) Inpatient and outpatient mental health services.

(e) Preventive services, including immunizations, prenatal and well-baby care, well-child physical examinations, and family planning services.

(f) Prescription drugs.

~~SEC. 9. Section 12725 of the Insurance Code is amended to read:~~

~~12725. (a) Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. For these purposes, "resident" includes a member of a federally recognized California Indian tribe. To be eligible for enrollment in the program an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage which the applicant could secure would (1) impose substantial waivers which the program determines would leave a subscriber without adequate coverage for medically necessary services, or (2) would afford such limited coverage, as the program determines would leave the subscriber without adequate coverage for medically necessary services, or (3) would afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates. Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in Section 10198.61, shall not be deemed to be rejection for the purposes of eligibility for enrollment. The board may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the board determines the enrollment can be carried out in an actuarially and administratively sound manner.~~

~~(b) Notwithstanding subdivision (a), the board may, by regulation, prescribe a period of time during which an individual is ineligible to apply for major risk medical coverage through the~~

~~program if the individual has voluntarily disenrolled from a private health plan after enrolling in that private health plan pursuant to Section 1366.51 of the Health and Safety Code or Section 10791 of this code.~~

~~(c) Subscribers and their dependents who become eligible for major risk medical coverage through the program may receive that coverage for no more than 18 months. At the end of the 18-month period, those subscribers and their dependents shall be guaranteed coverage pursuant to Section 1366.51 of the Health and Safety Code or Section 10791 of this code.~~

~~(d) The board shall provide a subscriber and his or her dependents with notice of the applicable termination date at least 60 days prior to that date, along with information concerning the ability to purchase a private health plan pursuant to Section 1366.51 of the Health and Safety Code or Section 10791 of this code.~~

~~SEC. 10.~~

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

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